MEETING MINUTES

Indiana State Uniform Billing Committee
September 21, 2017
MHS Offices – Clinton Room, 1st Floor
Indianapolis, Indiana

1. Welcome & Introductions

Jim Miller called the meeting to order at 2:01 p.m. EDT. Thirteen (13) committee members were present in person or by teleconference. Introductions of those in attendance followed. Jim Miller thanked MHS for hosting the meeting. Jim Miller stated that Danita Forgey had forwarded news that long-time IHIMA member and hospital friend Ruth Walker had recently pass away.

2. Review of June 22, 2017 meeting minutes

The minutes of the June 22, 2017 I-SUBC meeting were approved as submitted. Jim Miller reminded committee members that agenda and minutes from previous meeting, dating back as far as 2012, are available online on the Indiana HFMA web site at *www.hfma-indiana.org.*

3. I-SUBC administrative matters

Jim Miller confirmed that the annual subscription to the National Uniform Billing Committee (NUBC) was renewed (for 2017-2018) through June 30, 2018. He offered to provide NUBC meeting minutes or UB-04 manual data upon committee member requests.

4. NUBC update

NUBC meetings update -- April 4-5, 2017 in Chicago

Jim Miller reported on six (6) items discussed by NUBC during its two-day meeting in Chicago on April 4-5, 2017:

a. *Status of Shorter Duration/more frequent hemodialysis policy*
   CMS is receiving pushback on its medical policy regarding the frequency of hemodialysis services. CMS requested NUBC to postpone implementing its hemodialysis policy even though NUBC had already approved billing indicators (Revenue Code 0826, Value Code 84 and Condition Code 86) in anticipation of the new policy. NUBC agreed to postpone the implementation date beyond the original effective date (July 1, 2017) to a date yet to be determined.
b. *Off-campus provider-based outpatient departments (PBD)*
   NUBC members expressed several concerns about PBD-provider based outpatient departments. They included site locations (FL 01 on 837I), provider enrollment implications involving PECOS and FISS systems, and the use of modifiers –PN and –PO to distinguish non-excepted and excepted PBD services respectively. CMS agreed to provide a FAQ sheet for NUBC's review.
c. *New occurrence code for original hospice election or revocation date*
   CMS requested hospice election or revocation dates to be better reflected in EDI formats. NUBC members discussed the impact of changing incorrect/invalid hospice-related dates, how that might impact hospital-based vs. non-hospital based hospice units, and processing of adjustment/void claims when hospice election or revocation dates are changed. NUBC agreed to approve use of Occurrence Code 56 – Original Hospice Election Date or Revocation Date -- with the following definition: "Used when the hospice is submitting a

correction to the election date reported on a previous 08XA type of bill or the revocation on a previous 08XB type of bill. The hospice reports the correct dates in FL 06 – Statement coverage period (From-Thru) and the original date with Occurrence Code 56.

d. *Assignment of benefits certification indicator (UB04/7030 837 CLM08 synchronization*
NUBC reviewed the discrepancy between the upcoming 7030 version of 837 and UB04 on patient assignment of benefits "N" and "W" indicators. The "N" indicator is to be used when neither agreed nor refused to assign benefits, while the "W" indicator is to be used for actively used or refused. Discussion ensued among NUBC members about how indicators changed and emerged during X12 updates to 837I versions, thereby leading to confusion and discrepancies. After considerable discussion, NUBC agreed to contact X12 officials to revert to coding standard under 4010 version, using just standard "Y" or "N" indicators for patient assignment purposes.

e. *7030 topics discussion*
The claim guides for the X12 version of 7030 are available for review following the comment period that ended June 1, 2017. NUBC identified three outstanding issues/concerns about the X12 7030 version: (1) how claim code sets, previously managed by X12, will be "externalized;" (2) continuation of the transgender reporting issue, including X12's desire to expand current functionality to allow better reporting, concerns about health plans denying based on gender discrimination, use of new terms, such as "agender" and "genderfluid" in lieu of transgender, and Stage 3 of Meaningful Use data elements to reportedly include gender identity, birth sex and sexual orientation; and (3) Source of Payment typology, including the difference between 835 and 837 in source of payment (e.g., 837-Blue Cross; 835-Blue Cross PPO), use of various insurance plan coding at time of registration followed by payment differentials upon 835 postings, and formal end of Public Health Data Standards Consortium's request for payer data due to insufficient information from claims data.

f. *State, other issues*
NUBC discussed the need and appropriateness of the Unique Health Plan Identifier (HPID) when the burden of reporting the indicator may outweigh its benefits. A general consensus found that the HPID was another claim field for providers to complete and payers to adjudicate when other indicators would suffice, although NUBC agreed that a state-to-state review of plan data would help clarify the need.

NUBC discussed the use of the Ordering, Referring and Prescribing (ORP) physician indicators used by state Medicaid programs for fee-for-service (FFS) billing. Requiring ORP indicators on UB-04 claims has created Medicaid denials (e.g., in Florida and Wyoming) when UB-04 formats only recognize attending, operating and other physician identifiers. California Medicaid is currently in the midst of grace period for reporting ORP indicators. Once California's grace period ends, NUBC will revisit the entire ORP reporting indicators on UB-04 formatting.

Use of National Drug Codes (NDCs) by commercial plans is growing. Employer health plans in Florida and Minnesota are advocating use of NDCs for drug pricing purposes. NDCs provide better clarity of drug type, dosage, etc. than standard HCPCS reporting, which is helpful to employer groups in battling the rapid rise in drug costs. NUBC agreed to consider a change standard in UB-04 formatting from employer groups.

Jim Miller stated that NUBC met on August 8, 2017 in Baltimore and with the NUCC the following day (August 9, 2017), but the minutes to those meetings have not yet been posted on the NUBC web site.

UB-04 Change Implementation Calendar

Jim Miller reported on three (3) upcoming UB-04 changes/dates:

1) January 1, 2018: Form Locators 31-34 – New Occurrence Code for Hospital Election or Revocation
2) July 1, 2018: Clarification on Revenue Code 0206 – Intermediate ICU. Intermediate Care Units are also known as Step-Down units, Progressive Care Units and Definitive Observation Units. Revenue Code 0206 will be annotated as follows in the 2019 UB-04 Manual: XXX6-Intermediate ICU to include hospital inpatient step-down units, progressive care units and definitive observation units (non-outpatient unlike outpatient observation, which is reported under 0762).
3) July 1, 2018: New value code methodology contained in the 2018 UB-04 manual appendix will be implemented for paper claims only.

UB-04 Version 9.00 Clarifications/Errata/Updates

1) UB-04 Page 123: Intensive Care Unit Revenue Codes (020X): As of July 1, 2018: Clarification on Revenue Code 0206 – Intermediate ICU. Intermediate Care Units are also known as Step-Down units, Progressive Care Units and Definitive Observation Units. Revenue Code 0206 will be annotated as follows in the 2019 UB-04 Manual: XXX6-Intermediate ICU to include hospital inpatient step-down units, progressive care units and definitive observation units (non-outpatient unlike outpatient observation, which is reported under 0762).

Upcoming NUBC meeting schedule

NUBC will continue its monthly conference calls, with face-to-face meetings scheduled for April 17-18, 2018 in Baltimore and August 7-8, 2018 in Chicago. Both of those meetings will include a one-day gathering with NUCC officials.

5. Old Business:

a) CoreMMIS/Portal update

A lengthy discussion ensued regarding issues/concerns, etc. about the Indiana Medicaid Core/MMIS system. Sheri Hampton of American Senior Communities reiterated her concerns about overpayments and adjustments on nursing facility claims. Jeff Chapman of FSSA reported that reprocessing of affected nursing facility claims will begin in late September with resolution of accounts in 2-3 weeks (approximately mid-October 2017). Tonya Satterfield of R1RCM for St. Vincent's inquired about the processes involving access to the CoreMMIS Portal, including log-on procedures, identifying MDwise members through their assigned delivery system, and adding delegates/users through the designated provider administrator. Virginia Hudson of DXC confirmed the CoreMMIS added MDwise delivery system information in September 2017. Committee members agreed to monitor CoreMMIS issues and report them accordingly.

b) Health Plan Identifiers (HPID) update – refer to comments made earlier in meeting

Jim Miller referred to comments made earlier in the meeting regarding the HPID. No further discussion ensued.

c) Unique Device identifiers (UDI) update

A brief discussion ensued regarding reporting of UDI on claims and in medical records. Jim Miller stated UDIs are to be compiled in the GUDID -- a national database administered by FDA that will serve as a reference catalog for every device within a UDI (Unique Device Identifier). He noted that providers have expressed concerns about IT systems not being ready to accommodate UDI, how data on already implanted devices would be digitally or manually entered into hospital HER, and the UDI numbering

format and non-standardization. I-SUBC will continue to monitor progress on UDI reporting and record-keeping as its continues its seven-year implementation.

d) SSNRI/MBI update

Jim Miller reported that SSA hosted a webinar on September 18, 2017 that detailed information pertaining to the MBI (Medicare Beneficiary Identifier) implementation, beginning in 2018. He noted SSA has already changed the initiative name to "New Medicare Card" and that the outreach to the provider and Medicare beneficiary communities has significantly increased in recent months. He noted that Medicare will link the next randomly-selected MBI number to the current HICN and that access to a data base for both identifiers will be available to providers and Medicare MACs. Information about the "New Medicare Card" initiative is available at cms.gov/newcard.

e) Medicare hospital-based ambulance claims

No further discussion ensued. Jim Miller stated the item was requested to be added to the agenda by an undetermined committee member and that it would remain on the agenda for the next meeting.

f) QMB postings on Medicare remittance advices

Jim Miller reminded committee members that Medicare will begin posting QMB (Qualified Medicare Beneficiary) information on Medicare remittance advices and summary notices (for claims processed on or after October 2, 2017.) Further information about the addition of QMB data can be found in *MLN* 9911.

6. New Business:

a) FISS update –no report (Janet Mateo was in hospital recently)

Jim Miller reported that Janet Mateo of WPS had recently been hospitalized and would not be providing a FISS update. No further discussion ensued.

b) Modifier to identify all non-340B acquired drugs

Jim Miller reported that the 2018 proposed OPPS rule included a proposed 29% reduction in separately payable drugs and biologicals purchased under 340B. The proposed rule recommended a reduction in 340B-purchaed drug payment from ASP (Average Sale Price) + 6 to ASP – 22.5%. CMS estimated the proposed payment cut would provide $4 billion in annual program savings. To accommodate the proposed reimbursement cut and identify Part B drugs **not** acquired through 340B, CMS is recommending a new modifier – to be determined – that would be used effective January 1, 2018. Jim Miller noted hospital systems will have difficulty in getting systems ready for this major change by January 1, 2018: adding/testing the new modifier, identifying appropriate drugs from the 340B inventory, etc. He cited hospital providers' difficulty in implementing the –JW modifier earlier this year – to report drug wastes to the Medicare program. A brief discussion ensued regarding the anticipated difficulty in implementing a significantly new modifier in such short order.

c) ICD-10 update – getting down to specifics

Jim Miller stated that a *Healthcare Finance News* online news article (September 17, 2017) reported that just 400 new ICD-10 codes will be added, as of October 1, 2017, and that CMS and other insurers will now focus on narrowing down specificity in the clinical documentation to make sure the coding accurately reflects the actual care provided. Danita Forgey confirmed that in the coming year more emphasis will be placed on clinical validation to support the coding provided. She cited respiratory failure, malnutrition and sepsis as three conditions that will be especially scrutinized by government and private insurers.

d) MCE issues with data coming from State as a possible reason for NPI-related denials

A discussion ensued regarding identified denials involving the flow of provider file information from DXC Title XIX to the managed care entities. Committee members discussed the linkage of rendering providers to group billing providers and how that linkage applies to physical address/site billing. Virginia Hudson of DXC Title XIX remarked that an IHCP bulletin *(BT201715),* February 14, 2017, outlined how provider

linkage works in CoreMMIS. She added IHCP Banner Page *BR201719* (dated May 9, 2017) announced that claim editing for EOB 1010 had been suppressed until September 1, 2017 to allow providers to update provider linkages and receive claim payments.

e) *PT/OT/SP done in hospital vs. office setting*

A brief discussion ensued regarding the difference in billing formats for rehab services (physical therapy, occupational therapy and speech language pathology) between hospital outpatient departments and outpatient clinics.

7. Open Discussion

Virginia Hudson of DXC Title XIX reminded committee members that the IHCP Annual Provider Seminar is scheduled for October 17-19, 2017 at the Indianapolis Marriott East Hotel. More information and online registration for the three-day seminar was not yet available (at the time of the I-SUBC meeting).

Jim Miller stated the I-SUBC would meet one more time in 2017 at a site to be determined. He noted that committee members will be contacted well in advance, once the meeting location is set.

There being no further business, the meeting adjourned at 3:48 p.m.

Respectfully submitted,

James E. Miller, Chairperson
Indiana State Uniform Billing Committee